December 2000 California Department of Mental Health

Performance Outcomes Update

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INSIDE THIS ISSUE:

"Wishing you a Safe and Happy Holiday Season"

Children and Youth Performance Outcome Update

A pilot test of a new Children's Performance Outcome System has begun. Five of the approximately 10 counties who volunteered to participate in the pilot have been trained as of the writing of this article and the remainder should be trained by mid-December. The new instruments and associated client information face sheets were presented at a Children's System of Care Evaluator's Conference hosted by the University of California San Francisco's Child Services Research Group. At that meeting, Children's Program Evaluators from around the state as well as quality management and clinical staff had an opportunity to provide feedback. Comments were almost unanimously positive.

Additionally, clinicians who have participated in training in the pilot counties have expressed satisfaction that the information being collected is relevent and important to assessing performance outcomes. "Now this is something that is doable", said one clinician in Sutter/Yuba Counties.

At a meeting of the California Department of Social Services Wrap-around Evaluation Project, DMH staff also presented the new instruments for comment. Again, feedback was positive with one Social Worker responding that "We have wanted this kind of information for a long time."

Future editions of the Performance Outcome Update will include early analyses of the data generated by the pilot and provide updates on its progress.

Would you like to contribute to the California Development of Mental Health's Performance Outcomes Update (POU)? If you or your county are using performance outcome data to improve your programs, or if you have identified a novel way to analyze data to determine program effectiveness, and would like to share this with others, why not submit an article to the POU? It needs to be concise and kept under 800 words. Send your article to Roxane Gomez, CA Department of Mental Health, 1600 9th Street., Room 130, Sacramento, CA, 95814, or rgomez@dmhhq.state.ca.us .

UPDATE ON THE ADULT PERFORMANCE OUTCOME SYSTEM

PROTOCOLS CLARIFICATION: Counties continue to inquire as to whether their inpatient clients are included in performance outcomes. The following is a clarification of the protocols in the Adult Performance Outcomes Training Manual relating to the administration of performance outcome surveys to long-term IMD clients, especially if they are being treated in another county.

? Must the performance outcome instruments be administered to inpatient clients (e.g., those being served in IMD's)?

Most clients who are seen within a county on an inpatient basis do not remain in that setting for more than 60 days. Eventually, they are either referred to a state hospital or begin being seen on an outpatient basis. Either way, the final definition that should be used to decide who receives the instruments and who does not is based on whether or not the client receives services for more than 60 days.

? What if a target population client is being treated out-of-county? Must the adult performance outcome instruments be administered to these individuals?

Yes. Typically, the instruments will be administered in the county where the client is being seen. Later, once the data have arrived at DMH, they will be associated with the client's county of fiscal responsibility. It is recommended that counties work out contractual agreements that specify the roles and responsibilities of each party as they relate to performance outcome data collection and reporting.

The bottom line is that IMD inpatients may meet the target population definition (seriously mentally ill clients expected to be in service 60+ days) and, if so, should be included in Performance Outcomes. This policy was recently reinforced by Ann Arneill-Py, Executive Officer of the California Mental Health Planning Council (CMHPC), who agrees with the language of the Protocols. In response to a county question about the inclusion of IMD patients, she answered that "the CMHPC cares about IMD clients. They are the most severely ill of all clients (except those in state hospitals). The department is working on outcomes for state clients so I don't see any reason to omit IMD clients. The Planning
Council would be particularly interested in the views of IMD patients on quality of life and their MHSIP responses.

UPDATE ON THE OLDER ADULT PERFORMANCE OUTCOME PILOT

? The Older Adult Performance Outcome Committee last met on December 12, 2000. At this meeting each county representative reported on the status of the pilot in their county and the committee continued its review of a revised draft of the face sheet. Shortly, the draft face sheet will be put on the RPOD web site so that interested parties can provide input. The next meeting is scheduled for January 11, 2001.

? Be sure to also check our web site hhtp://www/dmh.cahwnet.gov/rpod for an article comparing older adults with serious mental illness with older adults in the general population. The data in the report tables were obtained from a variety of sources and are intended to provide a limited baseline for interpreting results from the Older Adult Performance Outcome Pilot. Some of the variables compared are gender, ethnicity, marital status, education, and living arrangement. The older adult population in the pilot is quite similar to the general population on some of these variables (e.g., gender proportions) but dissimilar on others (e.g., marital status).

KENNEDY AXIS V AND THE DUALLY DIAGNOSED CLIENT

Dually Diagnosed (DD) clients are frequently considered more difficult to treat than other adults with serious mental illness because they come into treatment with two co-occurring, interacting disorders, i.e., substance abuse and a mental illness. Under the influence of mental symptoms and controlled substances, DD clients usually are functioning at a very low level in the community. Measuring this level of functioning at admission is important because it provides the baseline for comparison of treatment effectiveness. After all, the goal of treatment is to improve the client's ability to function in the community.

In the DD Demonstration Projects, the Kennedy Axis V (K Axis) is being used to measure the level of client functioning at admission to the project and over time. The K Axis is a clinician's rating of patient functioning in six areas: psychological impairment, social skills, violence potential, ADL-occupational skills, substance abuse, and medical impairment. The K Axis has not been tested or normed with DD populations and it was not known at the start of the DD projects how well it would work at measuring the level of functioning for Dually Diagnosed clients. Of particular interest is the average score on the substance abuse scale. One would expect the scores for DD clients to indicate more difficulty functioning in the area of substance abuse while other mentally ill clients would have higher scores. With the release of the interim report there are now admission scores for the DD clients data that can be compared with scores for other mentally ill adults to see if the K Axis does produce lower functioning scores for DD clients.

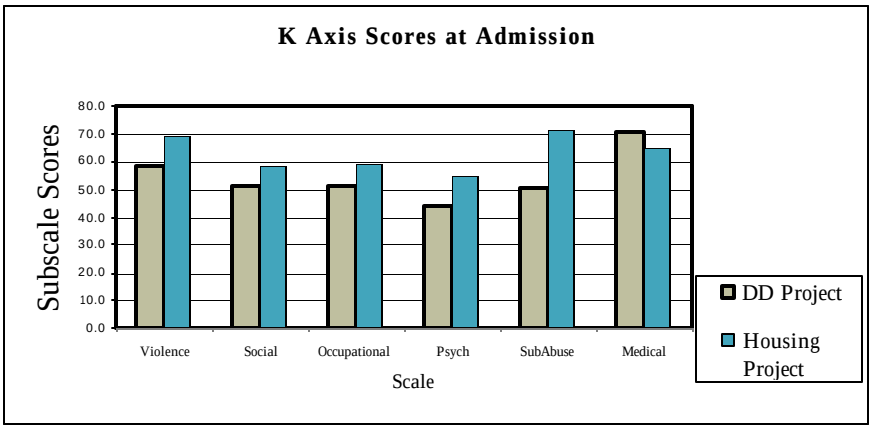
For comparison purposes, the average of the K Axis scores from one of the DD projects, San Diego, will be compared with data for adults receiving supportive housing services from the 13 supportive housing projects funded in 1999 by the Department of Mental Health. These housing projects serve individuals who have a serious mental illness and are homeless or at risk of becoming homeless. Some of these clients may be dually diagnosed as well.

As Table A shows, adults with serious mental illness receiving supportive housing services did have average K Axis scores that indicate higher levels of functioning in every category except for one, than the average score for the DD clients. Only on the medical impairment scale did the DD cases have a higher average level of functioning. For the remaining five scales, the supportive housing projects clients had higher average scores than did the DD clients. For example, on the Violence potential scale, DD clients average score was 58.4, indicating serious to moderate problems with anger and irritability, and moderate threats of violence. In contrast, the mentally ill adults receiving supportive housing services had average scores of 69.3, indicating mostly mild difficulty with anger and irritability.

The average scores on the substance abuse scale show the greatest difference. Since the DD clients are known to have a substance abuse problem, it is expected that their average score would be lower than scores for non-DD clients. On the substance abuse scale, DD clients had an average score of 50.9, indicating serious symptoms of substance abuse, moderate drug/alcohol seeking behavior, often intoxicated when driving or working, and moderate daily use of drugs such as marijuana, valium. The Supportive Housing clients, by contrast, have average substance abuse scores of 71.1, indicating mild impairment due to drinking, but generally functioning fairly well.

The better medical functioning of the DD clients is not easy to explain. It may be that the homeless or people at risk of being homeless have more medical problems to begin with. This issue needs more study.

It appears, from the first comparison, the K Axis does measure adequately the lower functioning of DD clients. A more thorough analysis will have to await the completion of the DD projects.



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WE'RE ON THE WEB
http://www/dmh.cahwnet.gov/rpod

SCHEDULE OF EVENTS

- Dec. 12, Older Adult Performance Outcomes Meeting
- Jan. 9, Children's Task Force Meeting
- Jan. 11, Older Adult Performance Outcomes Meeting
- Jan. 16, Adult Performance Outcomes Meeting Data Due!)

December 2000

Sun	Mon	Tue	Wed	Thu	Fri	Sat
10	11	**12** **Older Adult Mtg.**	13	14	15	16
17	18	19	20	21	22	23
24	**25** **Christmas Day**	26	27	28	29	30
31						

January 2001

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 New Year's Day	2	3	4	5	6
7	8	**9** **Children's Task Force Mtg.**	10	**11** **Older Adult Mtg.**	12	13
14	15	**16** **Adult Performance Outcomes Mtg.**	17	18	19	20
21	22	**23** QIC-lett's	24	25	26	27
28	29	30	31			